Provision of psychological services under Medicare: Broken but not beyond repair.

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The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative (Better Access) was designed to enhance access to mental health services and thereby improve the mental health of Australians. This paper focuses on that part of the initiative concerned with providing a rebate for psychological services and for the sake of brevity the term Better Access will be used to refer to this specific component, even though there are other elements of the initiative. Better Access provides funding for general psychological services and services provided by clinical psychologists. The central argument of this paper is concerned with the general psychological services component, which constitutes the large preponderance of psychological services funded under Better Access.

A distinctive feature of the psychological services (other than those provided by clinical psychologists) funded under Better Access is that they must be *Focused Psychological Strategies* (FPSs). Five such strategies are specified. All but one are components of Cognitive Behaviour Therapy (CBT). The other is Interpersonal Therapy (IPT), which is indicated as being appropriate for treatment of depression. The other key feature is that the number of funded sessions is limited (up to 10 in a calendar year). Most providers are psychologists but some social workers and occupational therapists can provide FPSs under Better Access.

By some indicators, Better Access has been a great success (Pirkis, Harris, Hall & Ftanou, 2011). From the perspective of the public, it has indeed increased access to psychological services by supporting a network of affordable providers. Where once, those without substantial means depended on services such as Lifeline and Centacare, today most communities will have a private psychology clinic where psychological services can be obtained with most of the cost subsidized by the Medicare rebate. From the perspective of the profession, Better Access has underwritten a vibrant, viable private practice alternative to employment in public health or community services. It has also opened up many new positions because for the most part the health and community services have persisted or expanded. From a public policy perspective, the public health goal of reducing the burden of illness of high prevalence disorders such as anxiety and depression by increasing the rate of treatment of these disorders also appears to have been met because many more people are receiving treatment.

So, is there problem? As I see it, there are important weaknesses in the system that adversely impact on clients, providers and public policy objectives. The system needs to be fixed if we are to achieve our aim of providing affordable, effective psychological services to the Australian public. Let's look at these weaknesses as they affect each of these interests, before considering what needs to be done to remedy the problem.

From the perspective of the client.

The approach taken by the Better Access scheme has two major weaknesses when considered from the perspective of the client. Both derive from wrong-headed treatment of psychological services as if they were analogous to a drug or medical procedure. At the core of the problem is the restriction of rebates to a delimited set of specified interventions – the FPSs. This has two serious consequences. The first is that the critical role of the client as an active agent in therapeutic change is compromised. The second is that there is no effective quality assurance mechanism.

The specification of treatment fails to take into the centrality of the client as an agent in the treatment process. Rather it treats the client as a passive recipient of a an intervention prescribed by an expert therapist. This is not to dispute that therapies such as CBT involve and even require active client engagement and collaboration. It is rather that, even before treatment commences, the position of the client is determined by the policy and funding framework of the Better Access scheme. The client is in effect told ' this is the therapy you need, please collaborate'. This is not only ethically problematic, it is inconsistent with national mental health policy (Australian Health Ministers, 2008) that seeks to empower the client and provide the client with every opportunity to be an active partner in treatment. Moreover, it is antagonistic to everything we know about what makes psychotherapy effective and is contrary to one of the core principles of evidence-based practice.

In this context it is worth referring to the American Psychological Association (APA) statement on evidence-based practice, which is explicit in indicating that choice of treatment should be made in the 'context of patient characteristics, culture, and preferences' (American Psychological Association, 2005). The APA statement goes on to say: 'Psychological services are most effective when responsive to the patient's specific problems, strengths, personality, sociocultural context, and preferences. Many patient characteristics, such as functional status, readiness to change, and level of social support are known to be related to therapeutic outcomes'.

The specification of a limited range of interventions unreasonably and unnecessarily restricts response to client characteristics, culture and preferences. It is a one size fits all approach that treats psychological interventions as if they are analogous to a drug and that their effects were unmediated by person who is asked to work with them. The reality is that psychotherapy is necessarily a negotiated activity and is likely to be most satisfactory and effective when the negotiations are not excessively constrained by third party specification of treatment.

Quality assurance is at the core of client interests because in a complex area such as psychological services, it is difficult for clients to make effective judgments about the quality of services they are receiving. As a starting point, we need to make a brief digression into the world of commerce. The reason for this is that

the problem of consumer judgment about quality is not restricted to psychology. People often lack information to judge the quality of goods and services they purchase. This is why 'brand-recognition', 'brand-trust' and 'brand-loyalty' are such key concepts in the world of commerce and marketing. The world of advertising is substantially devoted to brand promotion and the activation of purchasing behavior as a result. In the commercial world, brand does operate as something of a quality guarantee because market mechanisms mean that brands that fail to deliver on quality are ultimately replaced by those which do, despite the best efforts of advertisers of the declining brand.

With respect to the psychological services funded through Medicare, the specification of treatment is in effect an attempt to achieve quality assurance through branding. Behind all the science and evidence-based practice is a simple proposition. This is that CBT (or any other specified treatment) is a reliable product that you can trust. The government will therefore underwrite these trusted services but not other brands. The 'science' provides cover for this proposition. The government is assured by the academic and professional community that the evidence shows that brand-trust is warranted and that these are indeed quality services. There is no market mechanism to sort this out – no competition is allowed. It is a North Korean approach to service provision.

This top-down, paternalistic approach to service provision might be justified if there was in fact clear evidence that some 'brands' of psychological intervention were more effective than others. After all, the state does have a duty to protect citizens from ineffective or dangerous services – especially when the state itself funds these services. However not only is there an absence of evidence for superiority of CBT or any other brand, there is overwhelming evidence for brand equivalence. Furthermore, this is not recent knowledge. In 1998, I pointed to the important finding that CBT and IPT had been found to be equally effective in treatment of depression (King, 1998). I suggested then, that the most parsimonious explanation was that intervention characteristics played a minor role in treatment outcome. However, the response of Medicare to this evidence was simply to include IPT in the list of branded therapies funded under Better Access.

Since then a succession of studies and meta-analyses have consistently shown little if any difference in effect between purposeful psychological interventions, no matter what the brand (Wampold et al., 2002; Cape et al, 2010; Wampold et al, 2011; Cuijpers et al, 2012). While there is a respectable evidence-base to indicate the specified interventions are superior to no treatment in clinical trials with specified populations, it is the fact of intervention rather than the form of intervention that is critical. The evidence for treatment equivalence is now so overwhelming that even groups with vested interest in branded therapy have begun to acknowledge the futility of an approach to service delivery that relies on brands. The American Psychological Association formally declared last year that "variations in outcome are more heavily influenced by patient characteristics e.g., chronicity, complexity, social support, and intensity—and by clinician and context factors than by particular diagnoses or specific treatment 'brands'" (American Psychological Association, 2012)

What this means is that Better Access relies for quality assurance on branding that has no validity. Clients are not only reduced to unnecessary passivity as recipients or prescribed interventions. They are also mislead that by the implication that these prescribed interventions are of superior quality and effectiveness to alternatives that might suit them better.

From the perspective of the practitioner

The requirement that the practitioner employ a specific intervention in order that the client receive the benefit of Medicare funding is both demeaning and contrary to the principles of evidence based practice. It also has the effect of impelling the practitioner towards unethical modes of practice. It is demeaning in that it implies that the practitioner is not a responsible professional who is able to exercise reasonable judgment when choosing an intervention. It is contrary to the principles of evidence-base practice it wrongly equates evidence based practice with provision of empirically supported treatment.

In arguing for the relevance and importance of professional expertise and professional judgment, I am not suggesting that there should be no constrints on providers of psychological services. There will always be practitioners who are unprofessional in one or other respect and it is entirely reasonable to introduce mechanisms to detect and sanction unprofessional conduct when it occurs. However, specification of treatment is a very weak mechanism. Practitioners can and do advise Medicare they are providing CBT or some other specified therapy, even if this is not the case. Specification may in fact encourage this form of dishonesty. There are already in place professional and regulatory mechanisms designed to control unprofessional conduct of registered professionals. If the purpose of specification of treatment is to constrain unprofessional conduct, it would be much more effective to strengthen these regulatory mechanisms than to specify treatment. In any case, it is entirely unsatisfactory to take as a starting point the proposition that practitioners will not conduct therapy in the best interests of clients and must therefore be told what kind of therapy to provide.

Specification of treatment is manifestly incompatible with evidence-based practice. In the words of the American Psychological Association (endorsed by the APS and PACFA in Australia): 'Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.' The best available research at the present time does not indicate that any of the interventions prescribed by Medicare are superior to other interventions or suitable for all clients. Equally importantly, the available research must be integrated with clinical expertise in the context of client culture, characteristics and preferences. Treatment specification makes no allowance for any of these critical components of evidence based practice. In other words, Medicare is in effect requiring that practitioners abandon the principles of evidence based practice in order that their clients obtain fee relief.

This imposes a terrible and entirely unnecessary ethical burden. The practitioner must either practice in accordance with EBP principles)and, if necessary, lie about it) or refuse to provide services under Medicare, thereby denying access to those without financial resources to pay for the services themselves. The only reason this is not a source of outrage within the professional community is because a generation of psychologists has been erroneously taught that evidence-based practice consists of implementing so-called empirically supported treatments, which, for the most part, means CBT.

From a policy perspective

There are many reasons why treatment prescription under Better Access is bad policy. To start with, as argued above it is contrary to the interests of both clients and practitioners. However, there are other important and adverse policy implications of treatment prescription.

To begin with, it is bad policy to create an artificial monopoly. Prescription of treatment creates a limited pool of providers. Those providers are then well-placed to increase service costs. In the case of services under Better Access this occurs when psychologists or other providers impose 'gap charges' – fees over and above the Medicare rebate. There is nothing in principle wrong with a professional charging a fee that is higher than the rebate. Indeed, this is common practice for medical services. However, it tends to defeat the central policy objective, which is to maximize public access to effective psychological services.

Second, it is bad policy to fund services but have no capacity for quality assurance of these services. Better Access can and probably do call pretty much anything they choose to do cognitive behavior therapy (CBT). However, it does not follow that the interventions provided bear much relation to the treatment protocols used in the clinical trials that provided the basis for specifying the intervention in the first place. This problem does not greatly concern me simply because, as already stated, there is little reason to believe that treatment specificity or for that matter fidelity play a major role in outcome. However, it should greatly concern those who manage Better Access who presumably do believe that specifying intervention can by a guarantee of quality.

It would also concern the public if they knew that treatments billed as CBT had little relation to the manualised interventions used in the studies establishing their effectiveness. Since treatment prescription is the primary if not sole form of quality assurance in Better Access and it fails both because of unenforceability and ultimately because of irrelevance, it follows that there is not effective quality assurance despite the large sums of public money invested in the scheme.

Third, treatment prescription increasingly duplicates the impressive array of online self help CBT that the Commonwealth has funded over the past 10 years. Sites such as On Track (https://www.ontrack.org.au/web/ontrack), Anxiety Online (http://www.anxietyonline.org.au) and eCouch (https://ecouch.anu.edu.au) provide well-designed modularized, interactive CBT self-help. There are no fidelity problems (at least no provider violations), the

services are free and the evidence so far suggests they are both effective and acceptable to users (Andrews, et al, 2010). While many people will want or need face-to-face services, there is little merit in prescribing the same face-to-face services that are already available in a high quality online environment. Rather face-to-face services can and should be used to support online modules and/or to address issues or needs not addressed in the online modules. There may even be an argument for restricting use of Better Access to people who have already completed at least one set of online modules. This would depend on adequate crisis support services.

Is there a better alternative?

Fortunately there are better ways of meeting the needs of clients while fulfilling key policy objectives. The solution involves some elements of de-regulation and some elements of increased regulation.

There should be de-regulation both of interventions supported by Medicare and of the professions able to provide these interventions. For reasons set out above, there is no basis for prescribing interventions and good reasons not to prescribe them. Equally there is no basis for restriction of providers, which is contrary to Australia's competition policy and unnecessary for the protection of the public. There is no evidence that psychological interventions are more effective when provided by a designated professional group such as psychologists. Rather there is clear evidence that psychological interventions can be effectively provide by a wide range of health professionals, including nurses, and by appropriately trained non-professionals (Montgomery et al, 2010).

However, opening up interventions and providers should not occur without some appropriate and effective quality assurance and risk management. These can best be accomplished through a combination of routine outcome measurement and regulation of providers who currently operate outside of any regulatory environment.

Routine outcome measurement systems are well-developed, available at reasonable cost and their use may even enhance treatment outcomes (Shimokawan et al, 2010; Bickman et al, 2011). Essentially they work by means of client self report before or after each therapy session. These are submitted online and provide a record of response to treatment that can be made available to the therapist, the client and to third party funders such as Medicare. More importantly, they inform clinical decision-making. In practice this means that all parties (the client, the practitioner and the funder) have some useful information to assist key decisions such as when to end treatment, when to get a second opinion and when to fund more specialist treatment from a clinical psychologist or psychiatrist.

The Commonwealth already has a commitment to routine outcome measurement and has implemented a form of outcome measurement in publically funded mental health services. In my view, provision of Medicare funding should be directly linked to submission of session-by-session online

outcome measures. In other words, payment to the therapist is contingent upon client reports. This is a much more stringent, transparent and effective form of quality assurance than the current system. It requires the development of some IT infrastructure to support it but the back-end is already developed and so it is a matter of interface rather than starting from scratch.

It is essential that all providers of Medicare services are registered and subject to a regulatory body such as the Australian Health Practitioner Regulation Agency (AHPRA). This is to ensure that practitioners are bound by a set of ethical principles and a code of conduct and members of the public have recourse when services are provided unethically or in a manner that breaches the code. This is not without cost but the cost can be recovered in part through registration fees. Existing peak bodies such as the Psychotherapy and Counselling Federation (PACFA) of Australia and the Australian Counselling Association (ACA) set membership standards that provide a starting point for qualification of service providers but a body like AHPRA is much better suited to licensing and regulation.

These changes will not suit everyone. In particular the profession of psychology, which is the major beneficiary of Better Access, may be concerned that its pre-eminent position among providers will be threatened or that the income of members will be threatened. In my view, such fears are probably not well-founded. Psychologists remain well-placed to provide services and many will welcome the increased flexibility of service provision and the freedom from the ethical dilemmas that attend the existing scheme. Competition is likely to lead to innovation and greater responsiveness to the public, which ultimately will enhance rather than diminish the profession. Historically, trade guilds have resisted change and de-regulation and there is no reason to expect differently in this case. However, fear of the response of a trade guild is not an adequate reason to avoid reform.

These changes are not a panacea. Cost management will always be an issue in provision of services that have only weak natural limits. Routine outcome measurement is meaningful and adds significant value but it is just one indicator of progress and should inform rather than dictate clinical decision-making. Widening the range of therapies and therapists will inevitably bring into play a handful of crackpots who increase the workload of misconduct tribunals and even garner the odd headline. However these are manageable problems and, in my view, the benefits of reform clearly outweigh the limitations and problems.

In Conclusion

Public funding of the provision of psychological services under Medicare meets important public needs and core policy objectives. However, the current scheme (Better Access), with its reliance on prescribed therapy and a very restricted set of provders is critically flawed and is not serving consumers, providers or policy objectives. While it is broken, it is not beyond repair. Reforms that eliminate reliance of prescribed, brand interventions and that widen providers (while at the same time strengthening the regulatory umbrella) and that monitor service quality through routine outcome measurement will make it a more consumer

friendly, effective service. It is even possible that service costs will be better constrained.

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